



THE INSTITUTE
FOR
FAMILY HEALTH

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**Health Information Technology Policy Committee
Meaningful Use Subcommittee
Hearing on Patient and Family Engagement**

My name is Dr. Neil Calman and I am the President, CEO and a co-founder of the Institute for Family Health, a network of 16 full-time and 9 part-time primary health care centers, two family medicine residency training programs and over 40 grant funded programs for services to special populations, for teaching, and for health services research and policy work.

In 2002 the Institute invested in a state-of-the-art integrated practice management and electronic health record system which has become the “central nervous system” of our organization (Epic Systems, Verona WI). Long before the categories of meaningful use were developed our organization had identified the goals that we hoped to achieve with this investment: Improvement in quality, reduction in disparities in care, improved communication and trust with our patients and the community and a focus on community health in the neighborhoods we served.

The implementation of our system was informed by work we had been doing for years prior on health disparities – the poor outcomes experienced by people of color in the United States on almost every health care process and outcome measure. Through a dozen focus groups we ran in the community – targeted to understanding what people thought led to these poor outcomes – three themes emerged. The first was a recognition that there was an almost universal history of mistreatment by the healthcare system. People realized that they were not getting the best and most advanced treatments available, that they were treated like “ants in a line”, anonymous folks who repeatedly had their fears validated that the system just didn’t care what happened to them. The second was a mistrust of the healthcare system – some referred to it as the Tuskegee legacy while others reflected on their own experiences in the health care system or those of their family or friends. And the third was a sense that there was a huge communication problem between the health care system and themselves. Even when language differences were not present, the failure of providers to explain things to them in a way that they could understand and act on them – was a nearly universal experience.

So it was with these three things front and center in our vision of HIT – that we proceeded with our implementation. We committed to giving our patients the best and most advanced care possible, to finding every way possible to build trust between our centers and the communities they served and to use the system to bridge the communication gap between us and our patients.

The first goal – demonstrating that people were getting the best and most advanced primary and preventive care was the easiest. We decided that to appreciate this, our patients had to be able to see the computer screen themselves and understand the way this technology was helping them to get the very best care. Our choice of flat panel monitors, mounted whenever possible so the patient could see what was being documented throughout the encounter, was the most important factor. We continue to reject tablet PCs – touted by some as facilitating eye contact between provider and patient but completely inaccessible to patients as an educational device or as a tool to involve them more in the content of their clinical encounter. With monitors visible to the patients, decision supports, anatomical diagrams, flow charts, graphs of weights and blood pressures, medication lists, scanned photos from consultation reports, and a library of health education materials – all became accessible to be discussed during the encounter.

Another factor in demonstrating to people that they were receiving truly state-of-the-art care was our set-up of what we call our “electronic patient outreach team”. Using reports from the system, patients who are in need of either preventive interventions or those with chronic illnesses who have been lost to follow-up are called by the team and offered to be scheduled an appointment. Patients are told that this outreach is being prompted by our electronic health record, both to explain why it is not their provider calling them directly and to engender an appreciation for the technology that is supporting their care.

We are in the process of building a new center now – where all exam rooms are equipped with semicircular desks like the one pictured below that facilitate communication between provider and patient – explicitly using the computer as a tool that endeavor.



The second goal - improving trust - required more thought. For patients who lacked exposure to computers – especially in 2002 when we began – we realized that the computer itself could be a source of distrust. Who was looking at their information anyway? Why did everything they tell me need to be put in a computer? What was being put in the computer about them? To address these issues we programmed an after-visit-summary that included a complete annotated problem list, a complete medication list and a complete copy of the day's progress note written by the provider. Though the note was not always intelligible as written it demonstrated to people early on that there was nothing in the chart that we could not share with them – and looking at the note at home sometimes generated important follow-up questions. More recently our providers chose to remove the progress note from printing automatically as part of the visit summary and it is now optional to include it or not. Personally, I think these are moves in the wrong direction and we are still working on this issue.

Finally, improving communication with patients has been facilitated by the implementation of our patient portal “My Chart – My Health”. We named it to emphasize to our patients that primary ownership of their medical record is theirs. We believe this is a fundamental principal of care. Nobody – if starting from scratch – would design a system of documentation that was inaccessible to the very people who needed it most. Nor would they block the doctor-patient interaction from being benefited by the ease and convenience of the asynchronous communication that email affords. Our patient portal is now in use by over 8000 of our patients – folks who are almost exclusively low-income. And the functionality of the portal is increasing rapidly. Patients can make, change and cancel appointments online. They can securely message their providers, request referrals and medication refills and access an expansive library of health information through Medline plus – a consumer focused collection of health education information that we have linked to each diagnosis in the patients record and are in the process of linking to each active medication and each lab test as well.

In summary, while patients have a right to access their health information now, we must build on these rights to present information to patients where, when and how they need it and want it. We fundamentally assert through our actions that the patient is the primary owner of their health information and that in the new HIT enabled world we are creating, we, as caring medical providers, must learn to use the electronic health record to facilitate patients in achieving meaningful use of their own information.

A handwritten signature in black ink, appearing to read "Paul Calman" with a stylized flourish at the end.